BIHC
Belleville Integrative Health Centre

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Date of Initial Appointment: _____ **Update** _____

Confidential Client Information

Name: _____

Address: _____

_____
City Province Postal Code

Sex: ❑ M ❑ F Age:_____ Date of birth: _____
DD/MM/YYYY

Occupation: _____

Employer: _____

Emergency Contact Name:_____

Phone#: _____

Phone #: _____
❑ Home ❑ Work ❑ Cell

Phone #: _____
❑ Home ❑ Work ❑ Cell

Phone #: _____
❑ Home ❑ Work ❑ Cell

Email: _____

Preferred method of contact:
❑ Phone ❑ Email ❑ Do Not Contact

How did you hear about us?

_____

I agree to receive future email communications from B.I.H.C containing news, updates and promotions.
You may withdraw your consent at any time. ❑ YES ❑ NO

Accident Information

Is your condition due to an accident? ❑Yes ❑No Date of Accident: _____

- If so, what type?: ❑Auto ❑Work ❑Home ❑Other

Client Condition

Reason(s) for Visit: _____

When did your symptoms appear? _____

Change since onset of symptoms: ❑Improving ❑ No Change ❑Regressing

Rate severity of your pain on a scale from 0 (no pain) to 10 (severe pain) _____

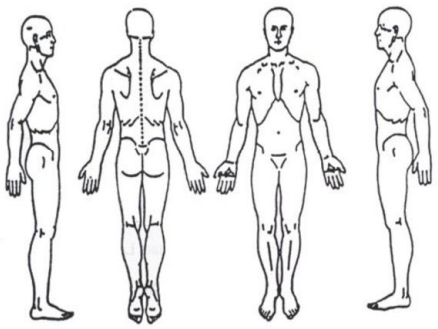
Type of pain: ❑Sharp ❑Dull ❑Throbbing ❑Numbness ❑Stiffness
❑Ache ❑Shooting ❑Burning ❑Tingling ❑Cramps

How often do you have this pain? _____

Does it interfere with your: ❑Work ❑Sleep ❑Daily Routine ❑Recreation

Activities or movements that are painful to perform: ❑Sitting ❑Standing
❑Walking ❑Bending ❑Lying Down ❑Twisting ❑Coughing/Sneezing

Indicate on the diagram where your symptoms are:



Please indicate if you have experienced any of the following recently:

❑ unexplained weight changes ❑ difficulty sleeping ❑ fever or night sweats ❑ vision changes ❑ unexplained dizziness

What is your overall health status? _____

Health History

Family Physician :_____ Physician's Phone Number _____

Present involvement in other health care: ❑Chiropractic ❑Acupuncture ❑Physiotherapy ❑Massage ❑Naturopathic ❑Chiropody/Podiatry ❑Occupational Therapy ❑Psychology/Psychiatry ❑Other _____

_____

Treatment To Date: Have you received any medical and/or drug treatment for this complaint? ❑Yes ❑No

Please provide details: _____

Surgery/Specialist Consultation:

Surgery: _____ Date:_____ Surgery: _____ Date:_____

Surgery: _____ Date:_____ Surgery: _____ Date:_____

Tests / Imaging: Have you had any of the following tests for the condition(s) for which you are presently referred?:

❑X-rays ❑Ultrasound ❑CT Scan ❑MRI ❑Bone Scan ❑EMG ❑Blood Test ❑Other: _____

Please check off all health conditions that apply:

❑Allergies: _____

_____

❑Anemia
❑Appendicitis
❑Artificial Joints
❑Asthma
❑Bleeding Disorders
❑Bowel/Bladder Changes
❑Brain/Head Injury
❑Bronchitis
❑Cancer
❑Cataracts
❑Chemical Dependency
❑Concussions
❑Congestive Heart Failure
❑Constipation
❑Depression/Anxiety
❑Diabetes (Type_____)

❑ Diarrhea
❑ Deep Vein Thrombosis
❑ Eating Disorder
❑ Emphysema
❑ Epilepsy
❑ Fainting
❑ Fibromyalgia
❑ Fractures
❑ Frequent Colds
❑ Gastrointestinal issues
❑ Glaucoma
❑ Gout
❑ Headaches/Migraines
❑ Heart Attack
❑ Heart Disease
❑ Hepatitis
❑ Hernia
❑ High Blood Pressure
❑ High Cholesterol

❑ HIV/AIDS
❑ Irritable Bowel Syndrome
❑ Internal Pins/Plates
❑ Kidney Disease
❑ Liver Disease
❑ Loss of Sensation
❑ Low Blood Pressure
❑Menopause
❑Multiple Sclerosis
❑Nausea or Vomiting
❑Osteoporosis
❑Osteoarthritis
❑Pacemaker
❑Parkinson's Disease
❑Pneumonia
❑Pregnant: ____weeks
❑Rheumatoid Arthritis
❑ Ringing in ears
❑ Shortness of Breath

❑ Skin Conditions
❑ Sinus Problems
❑ Stroke/TIA
❑ Surgery
❑ Thyroid Disorder
❑ TMJ Dysfunction
❑ Tuberculosis
❑ Ulcers
❑Varicose Veins
❑Vertigo
❑Vision Problems
❑Other: _____

_____

_____

Family Health History: ❑Heart Disease ❑Stroke ❑Arthritis ❑Cancer ❑Diabetes ❑Osteoporosis

Exercise

❑ None
❑ Occasional
❑ Frequent
❑ Daily

Work Activity

❑ Sitting
❑ Standing
❑ Light Labour
❑ Heavy Labour

Habits

❑ Smoking
❑ Alcohol
❑ Coffee/Caffeine Drinks
❑ High Stress Level

Medication

Medication	Dosage/Frequency	Condition It Treats